Name of Child_____ **Date of Birth**_____**Grade**_____

DC Overnight Field Trips
HEALTH HISTORY and MEDICATION FORM

EACH STUDENT should have this form filled out by a parent or legal guardian taking any medication on an extended field trip outside of the regular school day. Medication includes prescription, over the counter, herbal/homeopathic, and (non) essential oils. **Return this form along with a photocopy of your insurance card and any necessary medication** to your school's health assistant 2 weeks prior to departure (if able) allowing for necessary review and planning.

- All medications must be checked in to the school health assistant unless medication is designated as a self carry (**ONLY meds that can be self carried are inhalers and epi pens**).
- Epi pens/inhalers must have the appropriate emergency care plan attached to this form (if already present at school that will work as well, please indicate this on this form below) - these can be found on our website under parent links and resources & links.
- Please make sure to have a Medical Provider sign this form, they must have prescriptive authority in the state of Colorado.
- Parents/legal guardians please make sure to sign.
- Please remember trip staff do not carry any medications to give as needed, if your student might need an over-the-counter med, etc that must be filled out below as instructions detailed below.
- Please only include what is essential and necessary.

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1:
Name_____Email_____
Tel # (H)_____ (C)_____(W)_____

Parent/Guardian #2:
Name_____Email_____
Tel # (H)_____ (C)_____(W)_____

Emergency contact: Name: _____ Relationship:_____ Tel #: _____

MEDICAL HISTORY and MEDICATION

Medical History: Does or has your child received medical care for any of the following:

☐ Asthma ☐ Diabetes ☐ Kidney Disease ☐ Orthopedic ☐ Seizure
☐ Concussion/Head Injury ☐ Heart Disease ☐ Mental Health ☐ Other_____

Health Concerns: Does your child have any additional health concerns we need to be aware of? ☐ Yes ☐ No
If YES, please describe:_____

Name of Child_____ **Date of Birth**_____**Grade**_____

Allergies: Does your child have any severe allergies? ⬜Yes ⬜ No

If YES, what is your child allergic to? _____

Medication(s):

*All medications require the health care provider to sign below acknowledging the medications they authorize to be given by school trip staff.

*All **emergency** medications require an appropriate emergency action plan signed by the health care provider, available on the DC website (under parent links and resources & links). Note: if already present and signed by the provider here at school, please indicate this on the form below so we can pull these for the trip.

MEDICATION	FREQUENCY (as needed, daily, etc)	TIMES TO BE GIVEN (INDICATE AM/PM SPECIFICALLY)	DOSAGE	ROUTE	REASON TO BE GIVEN/SPECIAL INSTRUCTIONS/SIDE EFFECTS TO REPORT

Health Care Provider Authorization for above medications:

Health Care Provider with Prescriptive Authority signature:_____**Date:** _____

Printed Name of Health Care Provider with Prescriptive Authority: _____

Phone Number of Health Care Provider with Prescriptive Authority: _____

Sunscreen, lip balm, and insect repellent are to be provided by the parent but do not require a medical provider signature. I give permission for my child to apply these items while on the trip.

Parent/guardian signature _____

Name of Child_____ **Date of Birth**_____**Grade**_____

When providing medication to the school, please adhere to the guidelines below:

a. For prescription medications, please only provide the amount of medication that will be needed during the trip plus two extra doses in case of emergency or spilled medication.

b. Medication must be in its original bottle with a pharmacy label attached. Over the counter medication must be in its original packaging and labeled with your child's name.

c. Staff are not permitted to split pills - please provide pills already split if your child's dose requires a partial pill.

d. Please check the expiration dates on the medications before turning them in. We cannot accept any expired medications.

MEDICAL PROVIDER INFORMATION

Primary care provider: Name_____ **Phone Number:** _____

Dentist: Name_____ **Phone Number:** _____

By signing below, I give the school nurse permission to share information with field trip staff as determined appropriate for my child's health and safety.

Parent Signature: _____**Printed name**:_____
Date:_____

INSURANCE INFORMATION

Insurance Company: _____

Group Number: _____

Member Number: _____

Policy Holder's Name: _____

Claims phone number: _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD, THANK YOU.

Form reviewed by School Nurse/CCHC _____ Date: _____